

**MEDICAID DISEASE AND CARE MANAGEMENT
DEMONSTRATION PROGRAMS RFP
Questions & Answers - Set 1
April 22, 2005**

The responses to questions included herein are the official responses by the State to questions posed by potential bidders and are hereby incorporated into the Medicaid Request for Proposals (RFP) issued March 21, 2005. In the event of any conflict between the RFP and these responses, the requirements or information contained in these responses will prevail. (References refer to PART and page number of the RFP which addresses the question posed.)

PART I

1. What changes were included in the final budget regarding the Disease and Care Management procurement?

Changes adopted in the final budget include the following:

- a. The maximum number of six demonstrations was eliminated.
- b. The objectives of the CMD program were amended to address Medicaid-eligible recipients whose care and treatment results in high Medicaid expenditures not only because of one or more hospitalizations, but also because of "multiple disabling conditions requiring residential treatment".
- c. References requiring the DOH taking advantage of Federal Financial Participation (FFP) for the operation of the CMDs was eliminated.
- d. A fund was established in order to accept private payments and donations as support for the CMD program.

In addition, funding available for the demonstrations was increased substantially, and the potential term of operation of the demonstrations was lengthened as follows:

Previous and Current Approved Funding the CMD programs (in Millions)

Period	Previous Funding	Current Funding
Calendar Year 2004	\$3	\$3
Calendar Year 2005	\$1	\$3
Calendar Year 2006	-0-	\$7.5
December 1 – June 30, 2007	-0-	\$3.75
Total:	\$4M	\$17.25M

The revised legislation is now included as Attachment 1A, a copy of which is included at the end of this document. See the "Official Modifications" section of this document.

2. Are Medicaid managed care plans exempt from bidding? Please confirm whether the recipients in the CMD project must remain in FFS Medicaid in order to be eligible. (PART I-4)

A. Managed care organizations are eligible to participate as bidders as long as they meet the minimum qualifications for this RFP.

Recipients who are intervention enrollees may not be enrolled in a managed care plan because they are receiving care management services through the plan. If an intervention enrollee joins a managed care plan during the CMD project, they will no longer remain enrolled in the CMD.

3. Will overlap of vendors be allowed in the same area managing different subsets of the population? (PART I-4)

A. We will not select overlapping CMD programs that duplicate the services associated with a particular disease or affect the same target population of a previously selected CMD. Eligible enrollees can only be enrolled in one CMD regardless of the service area.

4. May a state entity, such as the NYS Veterans Home, or a state-operated psychiatric facility, apply? (PART I-4)

A. No, the legislation defines eligible sponsors as for-profit, not for profit and local government entities. A state owned or operated facility is not eligible to apply. See Attachment 1A.

5. Will the state reconsider requiring that bids are limited to operation in contiguous counties? (PART I-4, and PART II-9)

A. Yes, however the bidder's proposal must demonstrate the organizational structure, administrative capacity and staffing to provide equivalent CMD services for all counties included in the demonstration. This is an official modification of the RFP. See the "Official Modifications" section for details.

6. If the Demonstration is effective in reducing costs and improving quality of care, does the Department of Health intend to continue and expand the program after the two year demonstration period?

A. As noted in PART I-5, assuming funding is available it is the intent of the DOH to extend the term of successful models, and potentially expand the service areas involved.

7. Are clients of mental health institutions excluded from a CMD?

A. Yes. Refer to PART I, Section C.5.a, pg 5.

8. If a CMD enrollee loses Medicaid eligibility and then in the future is Medicaid eligible again, can the recipient re-enroll in the CMD? (PART I-5)

A. Yes, if the recipient is a FFS Medicaid recipient they may voluntarily re-activate their enrollment in the CMD.

9. Will there be a guaranteed eligibility period for the enrollees? If an individual fails to recertify, will they be eligible to continue the program to successfully measure their outcomes. (PART I-5)

A. There is no guaranteed eligibility period for enrollees, and enrollees cannot be mandated to remain in the CMD for any period. If there is a brief gap in Medicaid coverage, for example at the time of re-certification, the individual will still be eligible to continue as an intervention enrollee.

10. May a bidder propose a CMD which addresses recipients that are enrolled in the Lombardi (Nursing Home Without Walls) program? (PART I-5)

A. Yes.

11. Are you anticipating cost savings? If so, in what areas: hospitalizations, ER admissions, or other areas?

A. Yes, cost savings are one of the criteria for the final evaluation. See PART I, Section 9, pg 6, and Attachment 5.

12. How will Medicaid realize cost savings for dual eligibles enrolled in a CMD? (PART I-5, 6)

A. Although duals are included as potential target groups under these demonstrations, the savings are to be attributed to the Medicaid, not Medicare, program. We seek contractors with innovative ideas as to how this could be achieved.

13. Does the 5% saving apply to the total utilization by the intervention enrollees, or only the utilization directly related to the disease or condition being managed? (PART I-6,7)

A. The 5% savings will be measured based on the evaluation of total utilization, plus the costs of the interventions.

14. In order to save the required 5%, would CMDs be required to perform a power analysis on an equal number of enrollees? (PART I-7)

A. No. The DOH will be utilizing a control group pre/post methodology to evaluate the outcomes.

15. **PART I, D. 2, page 8 of the RFP describes the asthma and diabetes QIP as one of the current DOH patient management initiatives, and states that the CMD should not duplicate or overlap with these activities. Are recipients that are currently under treatment in the asthma or diabetes QIP going to be excluded from being included in a CMD?**

A. Yes. In identifying potential intervention enrollees for a CMD treating asthma or diabetes in a service area where the QIP operates, the DOH will exclude recipients who have the majority of their claims from the participating QIP clinics. These recipients are already receiving care under the guidance of a disease management program.

16. **Are we, therefore, to assume that the CMD is not to provide any asthma or diabetes related DM programs? (PART I-8, D.2)**

A. No. Bidders are advised however to assure that their target recipients do not include populations already under treatment via the QIP programs. **A complete list of the QIP clinic sites was distributed at the bidders' conference and is available on the DOH website.**

17. **Where can I get more information about the outcomes of the DOH/IPRO QIP disease management programs? (PART I-8)**

A. Information can be found on the IPRO website at www.IPRO.org.

18. **Can DOH provide information on the areas in which the Pediatric Asthma Initiative of the DUR program is operating? Are these recipients going to be excluded from a CMD? (Part I-8)**

The Pediatric Asthma Initiative was conducted within three regional asthma coalition's catchment area (Greater Capital District, Nassau/Suffolk and Western NY). This initiative concluded in 2004. Because of the very small size of this initiative, recipients included in this project will not be excluded from CMD projects.

19. **Would a disease management model that focuses on obesity as a chronic health condition and its link to hypertension, diabetes and coronary vascular disease be appropriate for this RFP?**

A. The DOH is seeking to test a variety of disease and care management models. There is no limitation on the specific chronic disease/conditions for which bidders may propose a CMD. However, bidders should assure that the CMD can demonstrate reduction in unnecessary use of hospital, emergency room and other high cost Medicaid services. Also the bidder's proposal should confirm that the CMD proposal will be able to produce changes in utilization as a result of the intervention during the contract term.

20. Can a bidder find out if they are qualified to bid prior to submitting a proposal?

A. The General Information section of PART I gives information on who may bid, service area requirements, bid limitations, etc. Minimum qualifications for this RFP are defined in PART II.B.2. If a bidder still has questions as to whether they are qualified to bid, they may submit a question in writing via email as described in PART III-2 of the RFP.

PART II

21. Is the EO127 "Contractor Disclosure of Contacts" form a required submission with the Letter of Intent? (Part II-2)

A. No. Submitting an EO127 form is not a requirement for submission of a Letter of Intent to bid.

22. Please clarify when and under what conditions a "Contractor Disclosure of Contacts" form is submitted for this procurement. (Part II-5 and Attachment 9)

A. These forms must be submitted as part of the proposal. The "Contractor Disclosure of Contacts" form must be completed for the bidder's designated contact person and any key individuals authorized to communicate with the State regarding this procurement process.

In addition, a "Contractor Disclosure of Contacts" form must be completed by the bidder for all contact names of reference clients or organizations, as well as all personnel reference contacts that are noted in the bidder's proposal.

23. Is the EO127 "Contractor Disclosure of Contacts" form required to receive the aggregate Medicaid data?

A. No.

24. Please clarify when and under what conditions a "Contractor Disclosure of Prior Non-Responsibility Determinations" form is submitted for this procurement? (PART II-2 and Attachment 9)

A. Each bidder and subcontractor must fill out and submit a "Contractor Disclosure of Prior Non-Responsibility Determinations" form with the bidder's proposal.

- 25. If the local district is sponsoring a proposal by a private sector care management company, does it still need to include the district's qualifications as described in PART II-2(b) Local Government Qualifications, or are the bidder's qualifications all that are needed? (PART II-2)**

A. Yes, if the local district submits the bid as the prime contractor. The minimum qualifications must be provided for the district. If the private-sector company is the prime contractor, and the local district is a subcontractor, the prime contractor (bidder) must submit the qualifications of the local district as a subcontractor.

- 26. What is the specific role of a local district that chooses to sponsor a proposal? Is the district expected to conduct any oversight or evaluation of the contractor's performance? If so, what activities is the district required to undertake? (PART II-2 and PART II-21, 22)**

A. If the local district submits the bid, they will serve as the prime contractor, and will be the legal entity responsible for the operation of the CMD, including full supervision and management of the contract, assurance that the subcontractor as well as the local district meet all terms and conditions of the contract, receipt of payment and payment of the subcontractor, assurance that all performance standards are met, payment of any penalties for non-performance, coordination of data and evaluation aspects with the DOH, etc. The district, as the prime bidder, must provide at least 30% of the total effort.

Alternatively, a local district can provide endorsement of the private sector bidder, who would serve as the prime bidder. Or the local district may serve as a subcontractor to the private sector bidder to fill specific functions other than those completed by the prime contractor.

- 27. Are there any minimum standards for a prime contractor? Can the prime contractor primarily supervise subcontractor(s) to get the work done?**

A. The DOH will not contract with a prime contractor when the subcontractor(s) is completing all, or the very large majority, of the work and operations associated with the contract. **The prime contractor must not only be responsible for meeting all of the contract provisions, but also must provide at least 30% of the total effort to implement and operate the CMD.** The bidder is required to report the percentage of effort completed by subcontractor(s) in their bid response (PART II.6.9.d). The total efforts provided by all subcontractors must not exceed 70%. This is an official modification of the RFP. See the "Official Modifications" section for details.

- 28. Regarding the inclusion of TP-1 forms for bidders' experience description: Please confirm that these forms are only required for describing each of the bidders' 3 required reference clients, as well as any other CARE MANAGEMENT projects for Medicaid programs. Example - a bidder could have numerous contracts with Medicaid agencies that are either non-care management related or only peripherally related to care management - Please confirm that TP-1 forms do not have to be completed for NON care management-related contracts. (PART II-5, II.B.2.a.7)**

A. This requirement is clarified to confirm that references only be submitted for Medicaid contracts related to care or disease management. This is an official modification of the RFP. See the "Official Modifications" section for details.

- 29. Does a contractor face any penalty if they do not achieve the 5% savings target? (PART II-6)**

A. There are no financial penalties for the contractor if the savings are not achieved. The CMD program does not utilize a contingency payment approach. Contractors will be paid for their CMD services based on the bid price.

- 30. Are the CMD programs responsible to pay the medical bills out of the money awarded in the contract or will claims be reimbursed by Medicaid directly?**

A. No. The FFS Medicaid program will continue to provide direct reimbursement for medically necessary care and services for intervention enrollees. The contractor will be reimbursed on a PMPM basis for the CMD services which are provided.

- 31. Should a bidder limit the number of intervention enrollees to keep cost of a demonstration low? (PART II.B.3.b.)**

A. A bidder should propose a demonstration size that will keep the total cost within the maximum allowed, be based on a competitive price and be a reasonable size to manage.

- 32. What is a reasonable number of enrollees for a demonstration? (PART II.B.3.b.)**

A. The number of enrollees proposed for a demonstration would vary dependent upon the disease(s) being addressed and the type intensity and cost of interventions being proposed.

- 33. Can a bidder propose a CMD for behavioral health? (PART II.B.3.b.)**

A. Yes.

34. Can a bidder select a service area that is less than an entire county? (PART II.B.3.b.)

A. Yes, a service area may be a catchment area within a county.

35. Is there a minimum or maximum number of patients per pilot project? (PART II-9)

A. No, there is no established minimum or maximum. The size of the intervention group is to be proposed by the bidder so that there is adequate participation to assure measurable outcomes.

36. Would a proposal be considered for an addiction services demonstration that focused on treatment of chemical dependency?

A. Yes as long as the proposed CMD meets all requirements of the RFP. Refer to PART II.B.3.b. page 9.

37. It appears that there is a bias for selection of a single disease versus management of overall health.

A. The DOH welcomes bids for both single disease states as well as a variety of other approaches. The bidders should submit a proposal for a population as indicated in PART I, page 2.

38. What will be the size of the control group? (Part II-10)

A. The control group will be a statistically valid sample, based on the approved size of the intervention enrollment group.

39. Will the intervention group and the control group be the same size? Is it a 1:1 randomization? (Part II-10, E-1)

A. No, the managed care group and the control group will not be the same size. The control group will be a statistically valid sample dependant on the size and scope of the proposal.

40. Will “health assessments” be done by the patient’s present providers or will we be required to do them? (PART II-12-13)

A. The bidder is responsible to assure that recipients under their care management program are assessed as to the need for potential intervention, and that the nature of the intervention is appropriate for that recipient. Generally it is expected that the bidder will design the assessment process, and complete it. If the bidder's model includes assessment by the recipient's present providers, the bid must indicate how the bidder will assure compliance and cooperation by the present providers.

41. What will the DOH's role be regarding the patients' present caregivers and medical personnel, including their MDs? Can the DOH assure participation by providers and caregivers? (PART II-13)

A. The DOH will provide information to assist the bidder to identify current providers, and may endorse approved mailings to encourage participation, but cannot mandate the participation by providers and caregivers. The DOH can also assist in identifying potential resources, such as professional medical organizations and other provider groups to assist the bidder in their outreach and provider education efforts about the CMD.

42. What kind of help will Medicaid give us to sign up patients for this project? (PART II-13)

A. The DOH may endorse approved mailings to the potential recipients to encourage their participation.

43. Who will collect data on the clinical performance measures? (PART II- 15)

A. The contractor is expected to collect the clinical performance measures data to confirm clinical performance outcomes.

44. Does the bidder have to rely on claims data to determine clinical outcomes? (PART II-15)

A. No. In addition to claims data, the contractors will be expected to collect data during the demonstration for the additional clinical outcome measurements which shall be incorporated into the evaluation.

45. What are our options if HMOs/insurers refuse to cooperate or give us needed data? (PART II-15)

A. The DOH may provide assistance and encouragement, but cannot mandate the provision of data, or other such cooperation. The CMD design should be based on a realistic ability to gather needed data.

46. What is your measurement methodology by which you are measuring results? Can you supply us with that methodology?

A. Financial impacts will be measured based on changes in utilization of Medicaid services. The specific methodologies for measurement of health outcomes will depend upon the individual proposal. Bidders are required to submit proposed methodologies for measurement of health outcomes, which shall be approved by the DOH. (See PART II-15, 8)

47. Will program results be measured on the intent-to-treat population or the consented population? (PART II-15, 8)

A. Both. Outcomes for consented populations or “actively managed” intervention population will be measured as part of the evaluation, and the outcomes of potential population (intent-to-treat) will also be reviewed to measure any potential bias.

48. Does the Medical Director need to be based in the State of New York? (PART II-20)

A. No.

49. PART II-23, section 9 refers to a phase down plan for the contract. Is this phase down period part of the two year contract term, or is that an additional period to follow the 24 month base contract?

A. The phase down will be included within the contract term of 24 months. If the contract is extended, the phase down will be the final month or so of the revised contract term.

50. Can bidders propose costs which include offsets through in-kind contributions? (PART II-24)

A. No, as indicated in PART II, Section C.2.a, bidders are required to submit a price bid that includes all actual costs incurred. The bid price may not be artificially reduced through offsets by donations from other entities or claims for potential Federal Financial Participation. This also includes offsets due to in-kind contributions.

51. During the four month ramping up process, we expect labor costs to be higher than subsequent months. Will reimbursement be able to reflect this? (PART II-25)

A. Bidders are required to submit a separate cost for the implementation period, which reflects the additional efforts required to complete labor-intensive start up activities.

52. If the contractor conducts outreach and assessment activities with potential enrollees and the individual does not enroll in the CMD, does the bidder/contractor receive any payment for those activities? In a voluntary program it appears that the contractor may invest considerable resources in the recruitment process with no revenue stream to support it. Could the bidder propose a one-time payment for the assessment of individuals who do not ultimately enroll? (PART II-25)

A. No, there is no separate PMPM for individuals who decline enrollment. The total bid price should include the estimated outreach activities for a larger population, as well as the ongoing care management costs for the subset of intervention enrollees.

53. Can CMDs begin actively enrolling intervention enrollees prior to the end of the four month implementation phase? (PART II-25)

A. No, while the CMD can be completing outreach and education about the program, and completing other activities to prepare for initial enrollments, all CMDs will have the same operational period of 20 months.

PART III

54. What is the required format for the Letter of Intent? (PART III-2)

A. The Letter of Intent must be on the official letterhead of the bidder's organization, with the signature of an official authorized to do so. The letter may be sent electronically as an attachment to an e-mail, or faxed. A hard copy must also be sent in the mail with an original signature. An email, without letterhead, will not be adequate. The Letter of Intent is non-binding.

55. What is included in the aggregate Medicaid data that is available to bidders? (PART III-3)

A. The standard report will be a category of service (COS) breakout (approximately 35 categories) for each disease type/counties listed in Attachment 2. The data will be provided in report format. See table below for a sample of aggregate data available for each disease state. Bidders that have submitted a non-binding Letter of Intent may request the aggregated data. The bidders will be provided the data on a CD sent via US mail. The CD includes a full explanation of the data in a file entitled "AA_Documentation.doc".

MEDICAID EXPENDITURES AND UTILIZATION IN CALENDAR YEAR 2003							
MEDICAID DISEASE AND CARE MANAGEMENT DEMONSTRATION PROGRAMS							
NEW YORK STATE DEPT. OF HEALTH / OFFICE OF MEDICAID MANAGEMENT							
NYS REGION (1) :	N	NYS COUNTY:	ALBANY	DISEASE GROUP:	ALL DISEASE GROUPS		
TOTAL Recipients	4,100						
TOTAL Expenditures	101,712,836						
TOTAL Medicaid-eligible Months	47,164						
AVERAGE Expenditures per Recipient	24,808						
AVERAGE Medicaid-eligible Months per Recipient	12						
PMPM	2,157						
Categories of Service (COS)	COS Dollars	COS PMPM	COS Dollars per COS Recipient	COS Claims / Days (2)		COS Claims / Days per COS Recipient	COS Recipients
Physician	1,652,733	35.04	454	92,129	Claims	25	3,640

Podiatry	21,309	0.45	34	2,748	Claims	4	620
Psychology	76,517	1.62	602	1,866	Claims	15	127
Eyecare	32,095	0.68	45	2,436	Claims	3	717
Nursing	676,267	14.34	48,305	4,603	Claims	329	14
OPD Clinic (hospital outpatient)	1,841,725	39.05	692	18,250	Claims	7	2,662
ER	542,050	11.49	279	5,393	Claims	3	1,945
FS Clinic (D&T center)	7,658,102	162.37	3,579	65,885	Claims	31	2,140
OMH Clinic	270,215	5.73	1,648	2,532	Claims	15	164
OMR Clinic	12,709	0.27	1,589	238	Claims	30	8
SSHSP	571,761	12.12	3,074	2,053	Claims	11	186
EI	49,618	1.05	3,817	657	Claims	51	13
Inpatient	14,054,569	297.99	8,958	15,513	Days	10	1,569
OMH Inpatient	0	0.00	0	0	Days	0	0
OMR Inpatient	0	0.00	0	0	Days	0	0
RTF	392,169	8.32	78,434	1,251	Days	250	5
SNF	17,256,670	365.89	35,003	124,417	Days	252	493
Dental	577,047	12.23	419	6,581	Claims	5	1,376
Pharmacy	18,838,405	399.42	5,030	226,922	Claims	61	3,745
Non-institutional LT Care	6,964,900	147.67	9,336	115,251	Claims	154	746
Personal Care	1,795,141	38.06	7,771	25,804	Claims	112	231
Home Health Care	1,774,871	37.63	3,935	17,077	Claims	38	451
LT Home Health Care	3,180,806	67.44	11,240	71,460	Claims	253	283
ALP	193,347	4.10	9,667	246	Claims	12	20
PERS Device	20,735	0.44	269	664	Claims	9	77
Laboratory	142,036	3.01	102	15,778	Claims	11	1,396
Transportation	347,340	7.36	247	6,024	Claims	4	1,406
HMO	0	0.00	0	0	Claims	0	0
CTHP	23,671	0.50	106	667	Claims	3	224
DME and Hearing Aid	598,286	12.69	531	13,239	Claims	12	1,127
Childcare	491,698	10.43	4,821	23,714	Days	232	102
Prepaid Mental Health	138,356	2.93	15,373	84	Claims	9	9
Referred Ambulatory	316,449	6.71	187	5,939	Claims	4	1,693
ICF-DD	3,216,099	68.19	19,976	33,664	Days	209	161
Community Rehab	22,539,825	477.90	33,050	58,214	Claims	85	682
Case Management	1,730,261	36.69	2,634	8,987	Claims	14	657
NOTES:							
(1) NYS regions -- 'Y' NYC, 'M' Metro, 'N' Northeast, 'W' West.							
(2) Definitions of 'COS claims / days':							
'Claims': Medicaid claims are counts of net claims.							
'Days': Medicaid days are days spent in an institution or hospital for which the Medicaid program pays.							
Data Source: NYS Dep. Of Health, Office of Medicaid Management, Audit, Fiscal, and Program Planning DataMart (claims paid through Feb. 2005).							
All claims in CY 2003 by dates of service (report run date: 4/8/2005).							

56. Does the data include point of service data for emergency room? (PART III-3)

A. Yes, emergency room (ER) data is included in the category of services report being provided.

57. Is it possible to have the data broken out by age? (PART III-3)

A. No, such a report is not available.

58. May additional data requests be made for other types of information? (PART III-3)

A. The DOH has limited capacity to generate additional aggregate data, but will consider other data requests. Any data generated as a result of such an ad hoc request will be made available to all potential bidders.

59. Is there a limit to the number of typewritten pages allowed for the Technical Proposal Response? (PART III-4)

A. The DOH is seeking concise proposals which clearly present the required information included in the RFP. The following limits apply to the maximum number of single sided typewritten pages for each section of PART II Volume I-Technical Proposal as indicated in the chart below. Required forms, charts, tables, sample material or financial reports are not included in the page count. Bidders that do not follow this formatting requirement will not fail the bid. However, point reduction will be taken from their evaluation score.

PART II- Technical Proposal	Page Limit
2. Qualifications and Experience	5 pages
a. Corporate Organization Qualifications	
b. Local Government Qualifications	
3. Technical Approach Proposed	
a. Management Summary b. Proposed Service Area c. Target population d. Scalability	3 pages
e. Demonstration Key Functions	20-25 pages
f. General Operations	8 pages

60. On what date will the CMD programs' contract commence? (PART III-1)

A. The CMD programs' contract is expected to begin October 3, 2005.

61. Is there a specific format for the bids?

A. Yes. Bidders must strictly follow the detailed response format prescribed in PART II, and the general requirements for the bid submission in PART III-4. Non-response to these requirements may result in a reduced score or a failure. A bidder's checklist is included in Attachment 8 to assure that all required information is returned with the bid. Bidders should complete the checklist and submit the checklist with their bid.

62. Can we request a complete set of raw data so that we can analyze which area we would like to submit a proposal for based on the data? (PART III-3, 4)

A. Bidders that have submitted a letter of intent may request aggregate Medicaid data related to the disease types, and/or counties in Attachment 2. Recipient-specific data will not be provided.

63. Would the state provide the names and/or backgrounds of the TET and FET members? (PART III-10, 11)

A. No.

64. How will proposals be evaluated for cost/price?

A. Refer to PART III, Section K.2.d, pg 11.

65. How will you define selection criteria- what are you looking for and how will you score?

A. Refer to PART III, page 11.3

66. Will the DOH award multiple awards in one region? (PART III-12)

A. Yes, however the demonstrations may not overlap specific disease activities or have a recipient enrolled in more than one demonstration.

ATTACHMENTS

67. What was the purpose of including the table of populations in Attachment 2 of the RFP? Are those the populations with which we will be working?

A. The populations exhibited in Attachment 2 of the RFP represent estimated Medicaid populations of several chronic diseases throughout New York State in calendar year 2003. Each population is composed of all fee-for-service (FFS) recipients who are Medicaid eligible at least 6 months in calendar year 2003. This table is meant to provide bidders with a general idea of the scope of size of a population of interest as part of their bid preparation. While many of these recipients

may be expected to carry over, a more recent population will be identified for purposes of intervention. There may be additional exclusions/changes made to the population based on subsequent agreements between DOH and the eventual contractor.

68. In Attachment 2, are the totals given for patients' present caregivers and medical personnel, including their MDs?

A. No, the data represents the number of recipients.

69. Does the DOH have a hierarchy of diseases established for diabetes? Would the DOH consider a renal failure management program for a patient with diabetes that is already enrolled in a disease management program? (Attachment 2)

A. No. The DOH has not established a hierarchy of diseases for diabetes. A patient that is already enrolled in a disease management program for diabetes would be excluded from enrollment in a CMD.

70. The State indicates that the contractor will be responsible for assigning a severity indicator to each recipient identified by DOH as a prospective CMD enrollee. What specific data will the state provide to the bidder/contractor for use in assigning these indicators (e.g. historical claims data)? (Attachment 4)

A. Contractors will be provided historical claims data in order to apply their approved severity indicator methodology.

71. Will Medicaid give us names of patient's Nursing Agencies or other providers, and contact personnel? (Attachment 4)

A. Data will be provided regarding current utilization, including current providers, consistent with DEAA standards. The DOH does not generally have "contact personnel" information available for all provider types.

72. Will vendors have access to laboratory test report values? (Attachment 4)

A. No. This data is not available on the MMIS claim file, and is not collected by the DOH.

73. How often will CMDs receive updated Medicaid utilization data for their intervention enrollees? (Attachment 4)

A. Updated utilization data will be provided monthly.

74. Will Medicaid send us lists of patients we can approach?

A. The contractor will enroll recipients identified by the DOH through the selection process identified in Attachment 4.

75. Will the DOH provide the CMD information (i.e. claims data) for the control group for internal auditing purposes? (Attachment 4)

A. No, the CMD will not be provided claims data for the control group.

76. Will the DOH select the control group after the vendor has stratified the population? Would you reconsider this stratification methodology strategy? (Attachment 4)

A. Yes, the control group will be selected after the potential intervention group has been stratified by the contractor. No, this methodology will not be reconsidered.

77. Would you consider a two-stage randomization process and collect health outcomes for the control group? (Attachment 4)

A. No.

78. Would you consider random selection of providers versus recipients? (Attachment 4)

A. No.

79. What is the length of claims lag for Medicaid claims? How long will it take for CMD to receive claims on active enrollees? (Attachment 4)

A. Generally paid claims for the preceding month will be available, but the lag in payment varies appreciably by provider type. Claims lag can be as much as 6 months depending on the individual provider. The CMDs will be provided updated data monthly on utilization by their intervention enrollees, which will include all claims received as of that date.

80. Will control and intervention group selection be refreshed monthly? (Attachment 4)

A. New potential intervention group enrollees will be provided by the DOH to CMDs as necessary, but no more frequently than quarterly. At the same time, additional control group selections may occur.

81. How will the enrollees be assigned? If they are patients who usually access care at HHC facilities they will be much easier to contact and affect an intervention. If they receive care outside of HHC, and maybe geographically distant the method of intervention will need to be very different. (Attachment 4)

A. Contractors may propose an approach that focuses on patients who receive their care primarily through a specific provider system, such as HHC. However the bidder must provide interventions for these recipients based on their total utilization, including other providers utilized by the recipient, not just care provided through the provider system.

82. Can we recruit patients in local hospitals and clinics? (Attachment 4)

A. The contractor may only enroll recipients identified by the DOH through the selection process identified in Attachment 4. However, if the contractor is able to provide identification information to DOH about potential replenishment recipients, these will be included in the selection process for additional enrollees to be provided to the contractor.

83. What type of data will be provided to contractors regarding the intervention enrollees? Will it be all claims data including pharmacy? In what format? (Attachment 4)

A. The type of data to be provided will be adjudicated Medicaid claims data. The format will probably be .txt but is open to discussion.

84. Can we use our own predictive model for identification purposes? If yes, can we get the full Medicaid population data for the geographic area we choose so that we can run our predictive model? (Attachment 4, Stage 1)

A. Bidders may use their own predictive model for identifying a potential target population, however, recipient specific Medicaid data will not be provided by DOH.

85. Who will stratify the sample, the contractor or the DOH? (Attachment 4)

A. The contractor will submit stratification criteria as part of the bid. Following approval by the DOH of these criteria, the contractor will complete the stratification consistent with the DOH-approved criteria. The DOH will then select the control group from among the stratified enrollees.

86. Please explain the DOH process of evaluating the CMD programs more fully. Attachment 5

A. The DOH final evaluation report will include both a review of the process and outcomes for the demonstrations, and will utilize both descriptive and analytical analyses. The key elements of the evaluation will be as follows:

- a. Changes in Medicaid health care utilization:** Using a 2-group pre/post design, the evaluation will look at types of changes in Medicaid service utilization. The analysis will utilize Medicaid claims data. Those identified by the DOH as potential enrollees, but who declined enrollment, will also be reviewed, primarily to assure that there was no bias in the enrollment process.
- b. Changes in Medicaid costs of care:** Using a 2-group pre/post design, the evaluation will look at the associated changes in costs for Medicaid services for the intervention group and the control group. The evaluation will review the changes in the total costs of care, but also focus on the changes associated with the specific CMD intervention.
- c. Health related outcomes:** Clinical outcome data, based on the approved clinical criteria provided by the contractor, and contractor collected data, will be evaluated to determine whether specific clinical indicators of change were achieved. The nature of the clinical outcomes evaluation, and the specific methodology applied, will vary based on the specific CMD being evaluated. This component of the evaluation will use some quantitative analysis, and may include one group comparison to expected norms from the literature, or comparison of clinical outcomes in a different region.
- d. Intervention Process:** A descriptive review of the types of interventions provided, and an analysis as to the quality and effectiveness of the services provided.

87. When will the pre/post evaluation begin? (Attachment 5)

A. The evaluation period will begin on the date of enrollment of the first intervention enrollee.

88. It would appear that there are actually three groups of recipients: the control group, opt-in group and the opt-out group. We recommend that all three groups be reported on because the actual opt-in group are a motivated group which will bias the results. (Attachment 5)

A. The DOH evaluation will address all three of these groups. However, the evaluation of the op-out group will be more limited and general in nature.

89. When conducting the final evaluation, will the DOH be evaluating just the impact of the intervention on the specific disease being managed? How will co-morbid conditions be evaluated? (Attachment 5)

A. The evaluation will focus on the specific condition(s) being addressed through the CMD intervention. However the evaluation will also review the total service utilization patterns as well. The impact of co-morbid conditions will be measured through appropriate statistical methods.

90. How will you separate out disease costs versus cost for treatment of co-morbid conditions of that disease? (Attachment 5)

A. The methodology will apply appropriate analytic techniques to control for relevant variables.

91. How will the evaluation of clinical outcomes be determined for the control group? (Attachment 5)

A. The evaluation methodology for the control group will be dependent on the specific types of clinical outcomes proposed by the contractor.

92. There are no clinical performance measures specified for seriously mentally ill adults in Attachment 6. Is the bidder expected to propose specific performance measures if it is proposing a CMD program for this population? Is there a minimum number of measures that should be included? (Attachment 6)

A. Yes, the bidder is expected to provide appropriate clinical performance measures for any CMD for which standard performance measures are not provided. These measures will be subject to DOH approval. No, there is no minimum number of measures that must be included. See PART II-15.

93. What is the definition of an actively managed enrollee for purposes of PMPM payment? (Attachment 7)

A. The bidder must submit their proposed criteria and specific definition of an intervention enrollee in their proposal. The DOH must approve the contractor's proposed definition. After Department approval, the PMPM payments will only be made for each enrollee meeting these criteria, who is concurrently enrolled in the Medicaid program, and not otherwise ineligible for enrollment.

94. How will billing be done? (Attachment 7)

A. The contractor will submit monthly invoices based on their approved PMPM roster and number of intervention enrollees. The DOH will confirm the accuracy of

the number of intervention enrollees being billed, consistent with the guidelines in Attachment 7.

- 95. Can the bidder propose two or more levels of PMPM rates based on enrollment? If only a small number of persons enroll voluntarily, the bidder/contractor has few lives over which it can spread its fixed costs. (Attachment 7)**

A. No, an average PMPM will be calculated based on the bidder's proposed costs and proposed intervention enrollees.

- 96. Will the DOH cap the total number of enrollees for the demonstration?**

A. The contractor will be monitored to assure compliance with the maximum payment amount approved under their contract. Should the total payments due the contractor, based on implementation costs paid, and ongoing PMPM payments, be projected to exceed the maximum approved contractual payments, the DOH will notify the contractor to adjust future enrollment activities. (Attachment 7)

- 97. Can the bidder/contractor put a cap on the total number of enrollees (at any given point in time) for the demonstration?**

A. Yes, the bidders proposal can impose limits on the monthly intervention enrollees to be managed, but cannot dis-enroll recipients to meet that standard. Rather, the bidder would be expected to slow down or stop additional enrollments to maintain the maximum enrollment. (Attachment 7)

- 98. Is it possible to obtain the required Bidder's Response Forms included in Attachment 8 in a Microsoft Word and Excel format?**

A. Yes. Send an email to ppno@health.state.ny.us (reference CMD RFP in the subject line) requesting the Bidder's Response Forms. The forms will be returned electronically via email.

GENERAL

- 99. Can a bidder combine the Medicaid CMD RFP request with the OASAS "Managed Addiction Treatment Services" RFP request?**

A. No. These two programs will be stand alone programs. The CMD cannot be an add-on to or an expansion of any other current proposal(s) or care management program.

100. Our organization has been awarded a Chronic Care Improvement pilot by CMS for Medicare beneficiaries in Brooklyn and Queens. Does this impact in any way our response to the Medicaid Disease and Care Management Demonstration?

A. Yes, the Medicaid CMD programs are meant to be stand-alone demonstrations that are not combined with other DM programs. A CMD cannot be an add-on to or expansion of other current proposal(s) or care management programs.

101. How can I get a copy of the handouts from the bidder's conference?

A. These materials are posted on the DOH website with the other procurement information.

102. What was the rate of compliance for getting flu shots for each of the patient populations mentioned in the RFP?

A. Information on compliance with flu shots is not available.

**MEDICAID DISEASE AND CARE MANAGEMENT
DEMONSTRATION PROGRAMS RFP
OFFICIAL MODIFICATIONS - Set 1
April 22, 2005**

The following are official modifications, which are hereby incorporated into the New York State Medicaid Disease and Care Management Demonstration Programs Request for Proposals (RFP), issued March 21, 2005. In the event of any conflict between the RFP and these modifications, the information contained in these modifications will prevail.

Section Page #	Specific Location	Current Language	Corrected Language (bold)
PART I-3	C	Legislation was enacted in 2004 which authorizes the Department to establish up to six (6) demonstrations (See Attachment 1).	Legislation was enacted in 2004 which authorizes the Department to establish disease management demonstrations. Legislation was amended in 2005. See Attachment 1A.
PART I-4	C.2	The service area for each demonstration may be a single region, one or more contiguous counties within a region, limited to a single social service district or a specific catchment area within a county.	The service area for each demonstration may be a single region, one or more contiguous counties within a region, limited to a single social service district or a specific catchment area within a county. The bidder's proposal must demonstrate the organizational structure, administrative capacity and staffing to provide and manage CMD services for the bidder's entire service area.
PART II-9	B.3.b	The proposed service area must be limited to a single region, however the service area proposed may be an entire region, one or more contiguous counties within a region, or limited to a single social service district or a specific catchments area (such as a municipality) within a county.	The proposed service area must be limited to a single region, however the service area proposed may be an entire region, one or more contiguous counties within a region, or limited to a single social service district or a specific catchments area (such as a municipality) within a county.

PART II-3,4	B.2.a.1)	The prime contractor must be able to meet the minimum qualifications (not with a subcontractor) in order to be considered for this bid.	The prime contractor must be able to meet the minimum qualifications (not with a subcontractor) in order to be considered for this bid. The DOH shall review the amount of effort provided by the prime contractor and proposed subcontractor(s). To be approved, a prime contractor must be responsible for meeting all of the contract provisions, but also must provide at least 30% of the total effort to implement and operate the CMD. The total combined effort for all subcontractor(s) operations, must not exceed 70%.
PART II-7	B.2.b.1	A qualified bidder must be a single, totally responsible prime contractor with any proposed subcontractors committed in writing to the intent of fulfilling specified roles identified in the bid.	A qualified bidder must be a single, totally responsible prime contractor with any proposed subcontractors committed in writing to the intent of fulfilling specified roles identified in the bid. The DOH shall review the amount of effort provided by the prime contractor and proposed subcontractor(s). To be approved, a prime contractor must be responsible for meeting all of the contract provisions, but also must provide at least 30% of the total effort to implement and operate the CMD. The total combined effort for all subcontractor(s) operations, must not exceed 70%.
PART II-5	B.2.a.7	Form TP-1, Summary of Experience and References, must be filled out for each State Medicaid program serviced by the bidder.	Form TP-1, Summary of Experience and References, must be filled out for each State Medicaid disease or care management program serviced by the bidder.

ATT. 2 Estimated Number of CMD Prospective Enrollees	Narrative, page 5, Utilization Threshold Screen	Three (3) or more Medicaid days in OMH licensed inpatient facilities (rate codes: 4001-4004, 1212, 2852, 2858).	Three (3) or more Medicaid days in OMH licensed inpatient facilities (rate codes: 4001-4004, 1212, 2852, 2858). <i>(Recipients with at least one OMH inpatient claim were excluded from the population.)</i>
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ATTACHMENT 1A
New York State 2005 Legislation
Authorizing Disease Management Demonstration Programs

6 s 21. The public health law is amended by adding a new section 2111 to
7 read as follows:

8 s 2111. Disease management demonstration programs. 1. The department
9 may establish disease management demonstration programs
10 through a request for proposals process to enhance the quality and
11 cost-effectiveness of care rendered to medicaid-eligible persons with
12 chronic health problems whose care and treatment, because of one or more
13 hospitalizations , **multiple disabling conditions requiring residential**
treatment or other health care requirements, results in high
14 medicaid expenditures. In order to be eligible to sponsor and to under-
15 take a disease management demonstration program, the proposed sponsor
16 may be a not-for-profit, for-profit or local government organization
17 that has demonstrated expertise in the management or coordination of
18 care to persons with chronic diseases or that has the experience of
19 providing cost-effective community-based care to such patients, or in
20 the case of a local government organization, has expressed a strong
21 willingness to sponsor such a program. The department may also approve
22 disease management demonstration programs which include, but are not
23 limited to, the promotion of adherence to evidence-based guidelines,
24 improvement of provider and patient communication and provide informa-
25 tion on provider and beneficiary utilization of services. The department
26 shall grant no fewer than six demonstration programs, no more than one-
27 third of such programs shall be selected to provide these services in
28 any single social services district; provided further, where the depart-
29 ment grants less than six demonstration programs, no more than one such
30 program shall be selected to provide these services in any single social
31 services district. The department shall approve disease management
32 demonstration programs which are geographically diverse and represen-
33 tative of both urban and rural social services districts. The program
34 sponsor must establish, to the satisfaction of the department, its
35 capacity to enroll and serve sufficient numbers of enrollees to demon-
36 strate the cost-effectiveness of the demonstration program.

37 2. The department shall establish the criteria by which individuals
38 will be identified as eligible for enrollment in the demonstration
39 programs. Persons eligible for enrollment in the disease management
40 demonstration program shall be limited to individuals who: receive
41 medical assistance pursuant to title eleven of article five of the
42 social services law and may be eligible for benefits pursuant to title
43 18 of the social security act (medicare); are not enrolled in a medicaid
44 managed care plan, including individuals who are not required or not
45 eligible to participate in medicaid managed care programs pursuant to
46 section three hundred sixty-four-j of the social services law; are diag-
47 nosed with chronic health problems as may be specified by the entity
48 undertaking the demonstration program, including, but not limited to one
49 or more of the following: congestive heart failure, chronic obstructive
50 pulmonary disease, asthma, diabetes or other chronic health conditions
51 as may be specified by the department; or have experienced or are likely
52 to experience one or more hospitalizations or are otherwise expected to
53 incur excessive costs and high utilization of health care services.

54 3. Enrollment in a demonstration program shall be voluntary. A partic-
55 ipating individual may discontinue his or her enrollment at any time

s. 6058--b

49

a. 9558--b

1 without cause. The commissioner shall review and approve all enrollment
2 and marketing materials for a demonstration program.

3 4. The demonstration program shall offer evidence-based services and

4 interventions designed to ensure that the enrollees receive high quality,
5 ty, preventative and cost-effective care, aimed at reducing the necessity
6 ty for hospitalization or emergency room care or at reducing lengths of
7 stay when hospitalization is necessary. The demonstration program may
8 include screening of eligible enrollees, developing an individualized
9 care management plan for each enrollee and implementing that plan.
10 disease management demonstration programs that utilize information technology
11 nology systems that allow for continuous application of evidence-based
12 guidelines to medical assistance claims data and other available data to
13 identify specific instances in which clinical interventions are justified
14 fied and communicate indicated interventions to physicians, health care
15 providers and/or patients, and monitor physician and health care provider
16 response to such interventions, shall have the enrollees, or groups
17 of enrollees, approved by the department for participation. The services
18 provided by the demonstration program as part of the care management
19 plan may include, but are not limited to, case management, social work,
20 individualized health counselors, multi-behavioral goals plans, claims
21 data management, health and self-care education, drug therapy management
22 and oversight, personal emergency response systems and other monitoring
23 technologies, telehealth services and similar services designed to
24 improve the quality and cost-effectiveness of health care services.

25 5. The department shall be responsible for monitoring the quality,
26 appropriateness and cost-effectiveness of a demonstration program. The
27 department shall utilize, to the extent possible, all potential sources
28 of funding for demonstration programs, including, but not limited to,
29 private payments and donations. **All such funds shall be deposited by the
commissioner and credited**

**to the disease management account which shall be established by the
comptroller**
**in the special revenue-other fund. Additionally, to the extent of funds
appropriated therefore, medical assistance funds, including any funding
or shared savings as may become available through federal waivers or
otherwise under titles 18 and 19 of the federal social security act, may
be used by the department for expenditures in support of the disease
management program.**

37 6. Payments shall be made by the department to the entity responsible
38 for the operation of the demonstration program on a fixed amount per
39 member per month of enrollment and shall reimburse the program sponsor
40 for the services rendered pursuant to subdivision four of this section.
41 the amount paid shall be an amount reasonably necessary to meet the
42 costs of providing such services, provided that the total amount paid
43 for medical assistance to enrollees in any such disease management
44 demonstration program, including any demonstration program expenditures,
45 shall not exceed ninety-five percent of the medical assistance expenditure
46 related to such enrollee that would reasonably have been anticipated
47 if the enrollee had not been enrolled in such demonstration
48 program. The department may make payments to demonstration programs that
49 provide administrative services only, provided that expenditures made
50 for enrollees, or a group of enrollees, participating in the demonstration
51 program shall provide sufficient savings as determined by the
52 department, had the enrollees, or groups of enrollees, not been enrolled
53 in such demonstration. The department shall provide an interim report to
54 the governor, and the legislature on or before december thirty-first,
55 two thousand six and a final report on or before december thirty-first,
56 two thousand seven on the results of demonstration programs. Both

1 reports shall include findings as to the demonstration programs`
2 contribution to improving quality of care and their cost-effectiveness.
3 in the final report, the department shall offer recommendations as to
4 whether demonstration programs should be extended, modified, eliminated
5 or made permanent.